Virginia Department of Medical Assistance Services
Family Planning Waiver Program
Fact Sheet

Purpose of the Waiver:	• To extend Medicaid coverage for family planning services to women who enrolled in Medicaid due to pregnancy. • To evaluate the impact of the waiver on birth outcomes; birth spacing and rates; and costs associated with labor and delivery and newborn/infant care.
Who is Eligible?	Any woman who meets all of the following criteria is eligible for the Family Planning Waiver: • Has received a pregnancy related service paid for by Medicaid during her most recent pregnancy; • Has not had a hysterectomy or tubal ligation; • Is less than 24 months from the end of her pregnancy; • Is not eligible for another Medicaid covered group; • Has income at or below 133% of the federal poverty limit; and • Meets citizenship and residency requirements.

What will this waiver offer?	The Family Planning Waiver provides Medicaid coverage for the following services for up to 24 months following the end of the month in which the pregnancy ends (actual coverage period is up to 22 months):
	• Family planning office visits which include:
	  o Annual Gynecological exam (one per 12 months);
	  o Sexually transmitted diseases (STDs) testing (limited to the initial family planning encounter);
	  o Pap test (limited to one every six months);
	  o Laboratory services for family planning and STD testing; and
	  o Family planning education and counseling;
	• Food and Drug Administration (FDA) approved contraceptives, including diaphragms, contraceptive injectables, and contraceptive implants;
	• Over-the-counter contraceptives; and
	• Sterilizations (excluding hysterectomies).

Non-Covered Services:	Individuals on the waiver are not eligible to receive other Medicaid services, to include the following: • performance of, counseling for, or recommendations of abortions; • infertility treatments; • performance of a hysterectomy; • transportation to a family planning service; • primary care services; and • any service not related to family planning.

How does a woman apply?	• No application is required. • Automatic enrollment for the MI Pregnant Woman occurs by the Department of Social Services (DSS) Eligibility Worker at the end of the Medicaid coverage (first day of month following 60 days postpartum) she received as a pregnant woman. • Women who had a Medicaid covered pregnancy whose income was greater than 133% FPL (non MI Pregnant Woman covered group) must provide the DSS worker with income verification prior to enrollment in the waiver. • Woman may request retroactive eligibility. • Recommend follow up with the DSS Worker to confirm enrollment. • Re-determination conducted by DSS Worker after 12 months from end of the pregnancy. Income verification required at redetermination period.
Primary Care Referrals:	• If a Family Planning Waiver recipient needs services other than those covered through the waiver, they should be referred to their primary care provider for these services. • If the recipient does not have a primary care provider, the recipient may be referred to a community or rural health clinic that provides care for free or on a sliding fee scale.
Provider Qualifications:	Services must be ordered, prescribed and directed, or performed within the scope of the licensed practitioner. The waiver recipient may access a Medicaid enrolled hospital, physician, nurse practitioner, medical clinic, or pharmacy to receive Family Planning Waiver Services.
Quality Assurance:	DMAS shall provide for continuing review and evaluation of the care and services paid through Medicaid including review of utilization of the services by providers and recipients. Providers will be subject to retraction if services provided do not meet the program criteria, if providers failed to maintain records or documentation to support their claims, or if providers billed for medically unnecessary services.